Amendment No.

CHAMBER ACTION

Senate House

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Representative Bean offered the following:

Substitute Amendment for Amendment (830641) (with title amendment)

Remove line(s) 5-464 and insert:

Section 1. Paragraph (d) of subsection (2) of section 112.363, Florida Statutes, is amended to read:

112.363 Retiree health insurance subsidy.--

(2) ELIGIBILITY FOR RETIREE HEALTH INSURANCE SUBSIDY.--

(d) Payment of the retiree health insurance subsidy shall be made only after coverage for health insurance for the retiree or beneficiary has been certified in writing to the Department of Management Services. Participation in a former employer's group health insurance program is not a requirement for eligibility under this section. Coverage issued pursuant to s.

408.9091 is considered health insurance for the purposes of this section.

Section 2. Subsections (5) and (10) of section 408.909, Florida Statutes, are amended to read:

408.909 Health flex plans.--

(5) ELIGIBILITY.--Eligibility to enroll in an approved health flex plan is limited to residents of this state who:

(a)1. Are 64 years of age or younger;

2.~~(b)~~ Have a family income equal to or less than 300~~200~~ percent of the federal poverty level;

~~(c) Are eligible under a federally approved Medicaid demonstration waiver and reside in Palm Beach County or Miami-Dade County;~~

3. ~~(d)~~ Are not covered by a private insurance policy and are not eligible for coverage through a public health insurance program, such as Medicare or Medicaid, ~~unless specifically authorized under paragraph (c),~~ or another public health care program, such as Kidcare, and have not been covered at any time during the past 6 months, except that:

a. A person who was covered under an individual health maintenance contract issued by a health maintenance organization licensed under part I of chapter 641 that also was an approved health flex plan on October 1, 2008, may apply for coverage in the same health maintenance organization's health flex plan without a lapse in coverage if all other eligibility requirements are met; or

b. A person who was covered under Medicaid or Kidcare and lost eligibility for the Medicaid or Kidcare subsidy due to

income restrictions within 90 days prior to applying for health care coverage through an approved health flex plan may apply for coverage in a health flex plan without a lapse in coverage if all other eligibility requirements are met; and

4.~~(e)~~ Have applied for health care coverage as an individual through an approved health flex plan and have agreed to make any payments required for participation, including periodic payments or payments due at the time health care services are provided; or

(b) Are part of an employer group at least 75 percent of the employees of which have a family income equal to or less than 300 percent of the federal poverty level and which employee group is not covered by a private health insurance policy and has not been covered at any time during the past 6 months. If the health flex plan entity is a health insurer, health plan, or health maintenance organization licensed under Florida law, only 50 percent of the employees must meet the income requirements for the purpose of this paragraph.

(10) EXPIRATION.--This section expires July 1, 2013 ~~2008~~.

Section 3. Section 408.9091, Florida Statutes, is created to read:

408.9091 Cover Florida Health Care Access Program.--

(1) SHORT TITLE.--This section may be cited as the "Cover Florida Health Care Access Program Act."

(2) LEGISLATIVE INTENT.--The Legislature finds that a significant number of state residents are unable to obtain affordable health insurance coverage. The Legislature also finds that existing health flex plan coverage has had limited

participation due in part to narrow eligibility restrictions as well as minimal benefit options for catastrophic and emergency care coverage. Therefore, it is the intent of the Legislature to expand the availability of health care options for uninsured residents by developing an affordable health care product that emphasizes coverage for basic and preventive health care services; provides inpatient hospital, urgent, and emergency care services; and is offered statewide by approved health insurers, health maintenance organizations, health-care-provider-sponsored organizations, or health care districts.

(3) DEFINITIONS.--As used in this section, the term:

(a) "Agency" means the Agency for Health Care Administration.

(b) "Cover Florida plan" means a consumer choice benefit plan approved under this section that guarantees payment or coverage for specified benefits provided to an enrollee.

(c) "Cover Florida plan coverage" means health care services that are covered as benefits under a Cover Florida plan.

(d) "Cover Florida plan entity" means a health insurer, health maintenance organization, health-care-provider-sponsored organization, or health care district that develops and implements a Cover Florida plan and is responsible for administering the plan and paying all claims for Cover Florida plan coverage by enrollees.

(e) "Cover Florida Plus" means a supplemental insurance product, such as for additional catastrophic coverage or dental,

vision, or cancer coverage, approved under this section and offered to all enrollees.

(f) "Enrollee" means an individual who has been determined to be eligible for and is receiving health insurance coverage under a Cover Florida plan.

(g) "Office" means the Office of Insurance Regulation of the Financial Services Commission.

(4) PROGRAM.--The agency and the office shall jointly establish and administer the Cover Florida Health Care Access Program.

(a) General Cover Florida plan components must require that:

1. Plans are offered on a guaranteed-issue basis to enrollees, subject to exclusions for preexisting conditions approved by the office and the agency.

2. Plans are portable such that the enrollee remains covered regardless of employment status or the cost-sharing of premiums.

3. Plans provide for cost containment through limits on the number of services, caps on benefit payments, and copayments for services.

4. A Cover Florida plan entity makes all benefit plan and marketing materials available in English and Spanish.

5. In order to provide for consumer choice, Cover Florida plan entities develop two alternative benefit option plans having different cost and benefit levels, including at least one plan that provides catastrophic coverage.

6. Plans without catastrophic coverage provide coverage options for services including, but not limited to:

a. Preventive health services, including immunizations, annual health assessments, well-woman and well-care services, and preventive screenings such as mammograms, cervical cancer screenings, and noninvasive colorectal or prostate screenings.

b. Incentives for routine preventive care.

c. Office visits for the diagnosis and treatment of illness or injury.

d. Office surgery, including anesthesia.

e. Behavioral health services.

f. Durable medical equipment and prosthetics.

g. Diabetic supplies.

7. Plans providing catastrophic coverage, at a minimum, provide coverage options for all of the services listed under subparagraph 6.; however, such plans may include, but are not limited to, coverage options for:

a. Inpatient hospital stays.

b. Hospital emergency care services.

c. Urgent care services.

d. Outpatient facility services, outpatient surgery, and outpatient diagnostic services.

8. All plans offer prescription drug benefit coverage or use a prescription drug manager such as the Florida Discount Drug Card Program.

9. Plan enrollment materials provide information in plain language on policy benefit coverage, benefit limits, cost-sharing requirements, and exclusions and a clear representation

of what is not covered in the plan. The Cover Florida Health Care Access Program shall require the following disclosure to be reviewed and executed by all consumers purchasing program options or insurance coverage through the program: "In connection with the Cover Florida Health Care Access Program authorized by s. 408.9091, Florida Statutes, agents and entities offering products and services under the program shall inform the named insured, applicant, or subscriber, on a form approved by the Office of Insurance Regulation of the Financial Services Commission, that the program is not an insurance program or, if it is an insurance program, that benefits under the coverage are limited under s. 408.9091, Florida Statutes, and that such coverage is an alternative to coverage without such limitations. If the form is signed by a named insured, applicant, or subscriber, it shall be presumed that there was an informed, knowing acceptance of such limitations."

10. Plans offered through a qualified employer meet the requirements of s. 125 of the Internal Revenue Code.

(b) Guidelines shall be developed to ensure that Cover Florida plans meet minimum standards for quality of care and access to care. The agency shall ensure that the Cover Florida plans follow standardized grievance procedures.

(c) Changes in Cover Florida plan benefits, premiums, and policy forms are subject to regulatory oversight by the office and the agency as provided under rules adopted by the Financial Services Commission and the agency.

(d) The agency, the office, and the Executive Office of the Governor shall develop a public awareness program to be

implemented throughout the state for the promotion of the Cover Florida Health Care Access Program.

(e) Public or private entities may design programs to encourage Floridians to participate in the Cover Florida Health Care Access Program or to encourage employers to cosponsor some share of Cover Florida plan premiums for employees.

(5) PLAN PROPOSALS.--The agency and the office shall announce, no later than July 1, 2008, an invitation to negotiate for Cover Florida plan entities to design a Cover Florida plan proposal in which benefits and premiums are specified.

(a) The invitation to negotiate shall include guidelines for the review of Cover Florida plan applications, policy forms, and all associated forms and provide regulatory oversight of Cover Florida plan advertisement and marketing procedures. A plan shall be disapproved or withdrawn if the plan:

1. Contains any ambiguous, inconsistent, or misleading provisions or any exceptions or conditions that deceptively affect or limit the benefits purported to be assumed in the general coverage provided by the plan;

2. Provides benefits that are unreasonable in relation to the premium charged or contains provisions that are unfair or inequitable, that are contrary to the public policy of this state, that encourage misrepresentation, or that result in unfair discrimination in sales practices;

3. Cannot demonstrate that the plan is financially sound and that the applicant is able to underwrite or finance the health care coverage provided;

4. Cannot demonstrate that the applicant and its management are in compliance with the standards required under s. 624.404(3); or

5. Does not guarantee that enrollees may participate in the Cover Florida plan entity's comprehensive network of providers, as determined by the office, the agency, and the contract.

(b) The agency and the office may announce an invitation to negotiate for the design of Cover Florida Plus products to companies that offer supplemental insurance, discount medical plan organizations licensed under part II of chapter 636, or prepaid health clinics licensed under part II of chapter 641.

(c) The agency and office shall approve at least one Cover Florida plan entity having an existing statewide network of providers and may approve at least one regional network plan in each existing Medicaid area.

(6) LICENSE NOT REQUIRED.--

(a) The licensing requirements of the Florida Insurance Code and chapter 641 relating to health maintenance organizations do not apply to a Cover Florida plan approved under this section unless expressly made applicable. However, for the purpose of prohibiting unfair trade practices, Cover Florida plans are considered to be insurance subject to the applicable provisions of part IX of chapter 626 except as otherwise provided in this section.

(b) Cover Florida plans are not covered by the Florida Life and Health Insurance Guaranty Association under part III of

chapter 631 or by the Health Maintenance Organization Consumer Assistance Plan under part IV of chapter 631.

(7) ELIGIBILITY.--Eligibility to enroll in a Cover Florida plan is limited to residents of this state who meet all of the following requirements:

(a) Are between 19 and 64 years of age, inclusive.

(b) Are not covered by a private insurance policy and are not eligible for coverage through a public health insurance program, such as Medicare, Medicaid, or Kidcare, unless eligibility for coverage lapses due to no longer meeting income or categorical requirements.

(c) Have not been covered by any health insurance program at any time during the past 6 months, unless coverage under a health insurance program was terminated within the previous 6 months due to:

1. Loss of a job that provided an employer-sponsored health benefit plan;

2. Exhaustion of coverage that was continued under COBRA or continuation-of-coverage requirements under s. 627.6692;

3. Reaching the limiting age under the policy; or

4. Death of, or divorce from, a spouse who was provided an employer-sponsored health benefit plan.

(d) Have applied for health care coverage through a Cover Florida plan and have agreed to make any payments required for participation, including periodic payments or payments due at the time health care services are provided.

(8) RECORDS.--Each Cover Florida plan must maintain enrollment data and provide network data and reasonable records

to enable the office and the agency to monitor plans and to determine the financial viability of the Cover Florida plan, as necessary.

(9) NONENTITLEMENT.--Coverage under a Cover Florida plan is not an entitlement, and a cause of action does not arise against the state, a local government entity, any other political subdivision of the state, or the agency or the office for failure to make coverage available to eligible persons under this section.

(10) PROGRAM EVALUATION.--The agency and the office shall:

(a) Evaluate the Cover Florida Health Care Access Program and its effect on the entities that seek approval as Cover Florida plans, on the number of enrollees, and on the scope of the health care coverage offered under a Cover Florida plan.

(b) Provide an assessment of the Cover Florida plans and their potential applicability in other settings.

(c) Use Cover Florida plans to gather more information to evaluate low-income, consumer-driven benefit packages.

(d) Jointly submit by March 1, 2009, and annually thereafter, a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives that provides the information specified in paragraphs (a)-(c) and recommendations relating to the successful implementation and administration of the program.

(11) RULEMAKING AUTHORITY.--The agency and the Financial Services Commission may adopt rules pursuant to ss. 120.536(1) and 120.54 as needed to administer this section.

Section 4. Section 408.910, Florida Statutes, is created to read:

408.910 Florida Health Choices Program.--

(1) LEGISLATIVE INTENT.--The Legislature finds that a significant number of the residents of this state do not have adequate access to affordable, quality health care. The Legislature further finds that increasing access to affordable, quality health care will be best accomplished by establishing a competitive market for purchasing health insurance and health services. It is therefore the intent of the Legislature to create the Florida Health Choices Program to:

(a) Expand opportunities for Floridians to purchase affordable health insurance and health services.

(b) Preserve the benefits of employment-sponsored insurance while easing the administrative burden for employers who offer these benefits.

(c) Enable individual choice in both the manner and amount of health care purchased.

(d) Provide for the purchase of individual, portable health care coverage.

(e) Disseminate information to consumers on the price and quality of health services.

(f) Sponsor a competitive market that stimulates product innovation, quality improvement, and efficiency in the production and delivery of health services.

(2) DEFINITIONS.--As used in this section:

(a) "Corporation" means the Florida Health Choices, Inc., established under this section.

(b) "Health insurance agent" means an agent licensed under part IV of chapter 626.

(c) "Insurer" means an entity licensed under chapter 624 that offers an individual health insurance policy or a group health insurance policy, a preferred provider organization as defined in s. 627.6471, or an exclusive provider organization as defined in s. 627.6472.

(d) "Program" means the Florida Health Choices Program established by this section.

(3) PROGRAM PURPOSE AND COMPONENTS.--The Florida Health Choices Program is created as a single, centralized market for the sale and purchase of various products that enable individuals to pay for health care. These products include, but are not limited to, health insurance plans, health maintenance organization plans, prepaid services, service contracts, and flexible spending accounts. The components of the program include:

(a) Enrollment of employers.

(b) Administrative services for participating employers, including:

1. Assistance in seeking federal approval of cafeteria plans.

2. Collection of premiums and other payments.

3. Management of individual benefit accounts.

4. Distribution of premiums to insurers and payments to other eligible vendors.

5. Assistance for participants in complying with reporting requirements.

(c) Services to individual participants, including:

1. Information about available products and participating vendors.

2. Assistance to participating individuals for assessing the benefits and limits of each product, including information necessary to distinguish between policies offering creditable coverage and other products available through the program.

3. Account information to assist individual participants to manage available resources.

4. Services that promote healthy behaviors.

(d) Recruitment of vendors, including insurers, health maintenance organizations, prepaid clinic service providers, provider service networks, and other providers.

(e) Certification of vendors to ensure capability, reliability, and validity of offerings.

(f) Collection of data, monitoring, assessment, and reporting of vendor performance.

(g) Information services for individuals and employers.

(h) Program evaluation.

(4) ELIGIBILITY AND PARTICIPATION.--Participation in the program is voluntary and shall be available to employers, individuals, vendors, and health insurance agents as specified in this subsection.

(a) Employers eligible to enroll in the program include:

1. Employers with 1 to 50 employees.

2. Fiscally constrained counties described in s. 218.67.

3. Municipalities with populations of fewer than 50,000 residents.

4. School districts in fiscally constrained counties.

(b) Individuals eligible to participate in the program include:

1. Individual employees of enrolled employers.

2. State employees not eligible for state employee health benefits.

3. State retirees.

4. Medicaid reform participants who select the opt-out provision of reform.

5. Statutory rural hospitals.

(c) Employers who choose to participate in the program may enroll by complying with the procedures established by the corporation. These procedures shall include, but not be limited to, the following:

1. Submission of required information.

2. Compliance with federal tax requirements for the establishment of a cafeteria plan, pursuant to s. 125 of the Internal Revenue Code, including designation of the employer's plan as a premium payment plan, a salary reduction plan with flexible spending arrangements, or a salary reduction plan with a premium payment and flexible spending arrangements.

3. Determination of the employer's contribution, if any, per employee, provided that such contribution is equal for each eligible employee.

4. Establishment of payroll deduction procedures, subject to the agreement of each individual employee who voluntarily participates in the program.

5. Designation of the corporation as the third-party administrator for the employer's health benefit plan.

6. Identification of eligible employees.

7. Arrangement for periodic payments.

(d) Eligible vendors and the products and services that they are permitted to sell are as follows:

1. Insurers licensed under chapter 624 may sell health insurance policies, limited benefit policies, other risk-bearing coverage, and other products or services.

2. Health maintenance organizations licensed under part I of chapter 641 may sell health insurance policies, limited benefit policies, other risk-bearing products, and other products or services.

3. Prepaid health clinic service providers licensed under part II of chapter 641 may sell prepaid service contracts and other arrangements for a specified amount and type of health services or treatments.

4. Health care providers, including hospitals and other licensed health facilities, health care clinics, licensed health professionals, pharmacies, and other licensed health care providers, may sell service contracts and arrangements for a specified amount and type of health services or treatments.

5. Provider organizations, including service networks, group practices, professional associations, and other incorporated organizations of providers, may sell service contracts and arrangements for a specified amount and type of health services or treatments.

6. Corporate entities providing specific health services in accordance with applicable state law may sell service contracts and arrangements for a specified amount and type of health services or treatments.

A vendor described in subparagraphs 3.-6. may not sell products that provide risk-bearing coverage unless that vendor is authorized under a certificate of authority issued by the Office of Insurance Regulation under the provisions of the Florida Insurance Code. Otherwise eligible vendors may be excluded from participating in the program for deceptive or predatory practices, financial insolvency, or failure to comply with the terms of the participation agreement or other standards set by the corporation.

(e) Eligible individuals may voluntarily continue participation in the program regardless of subsequent changes in job status or Medicaid eligibility. Individuals who join the program may participate by complying with the procedures established by the corporation. These procedures shall include, but are not limited to:

1. Submission of required information.

2. Authorization for payroll deduction.

3. Compliance with federal tax requirements.

4. Arrangements for payment in the event of job changes.

5. Selection of products and services.

(f) Vendors who choose to participate in the program may enroll by complying with the procedures established by the

corporation. These procedures shall include, but are not limited to:

1. Submission of required information, including a complete description of the coverage, services, provider network, payment restrictions, and other requirements of each product offered through the program.

2. Execution of an agreement to make all products offered through the program available to all individual participants.

3. Establishment of product prices based on age, gender, and location of the individual participant.

4. Arrangements for receiving payment for enrolled participants.

5. Participation in ongoing reporting processes established by the corporation.

6. Compliance with grievance procedures established by the corporation.

(g) Health insurance agents licensed under part IV of chapter 626 are eligible to voluntarily participate as buyers' representatives. A buyer's representative acts on behalf of an individual purchasing health insurance and health services through the program by providing information about products and services available through the program and assisting the individual with both the decision and the procedure of selecting specific products. Serving as a buyer's representative does not constitute a conflict of interest with continuing responsibilities as a health insurance agent provided the relationship between each agent and any participating vendor is disclosed prior to advising an individual participant about the

products and services available through the program. In order to participate, a health insurance agent shall comply with the procedures established by the corporation, including:

1. Completion of training requirements.

2. Execution of a participation agreement specifying the terms and conditions of participation.

3. Disclosure of any appointments to solicit insurance or procure applications for vendors participating in the program.

4. Arrangements to receive payment from the corporation for services as a buyer's representative.

(5) PRODUCTS.--

(a) The products that may be made available for purchase through the program include, but are not limited to:

1. Health insurance policies.

2. Limited benefit plans.

3. Prepaid clinic services.

4. Service contracts.

5. Arrangements for purchase of specific amounts and types of health services and treatments.

6. Flexible spending accounts.

(b) Health insurance policies, limited benefit plans, prepaid service contracts, and other contracts for services must ensure the availability of covered services and benefits to participating individuals for at least 1 full enrollment year.

(c) Products may be offered for multiyear periods provided the price of the product is specified for the entire period or for each separately priced segment of the policy or contract.

(d) The corporation shall require the following disclosure to be reviewed and executed by all consumers purchasing program options or insurance coverage through the corporation: "In connection with the Florida Health Choices Program authorized by s. 408.910, Florida Statutes, agents and entities offering products and services under the program shall inform the named insured, applicant, or subscriber, on a form approved by the Office of Insurance Regulation of the Financial Services Commission, that the products and services are not insurance or, if they are insurance, that benefits under the coverage are limited under s. 408.910, Florida Statutes, and that such coverage is an alternative to coverage without such limitations. If the form is signed by a named insured, applicant, or subscriber, it shall be presumed that there was an informed, knowing acceptance of such limitations."

(6) PRICING.--Prices for the products sold through the program shall be transparent to participants and established by the vendors based on age, gender, and location of participants. The corporation shall develop a methodology to evaluate the actuarial soundness of products offered through the program. The methodology shall be reviewed by the Office of Insurance Regulation prior to use by the corporation. Prior to making the product available to individual participants, the corporation shall use the methodology to compare the expected health care costs for the covered services and benefits to the vendor's price for that coverage. The results shall be reported to individuals participating in the program. Once established, the price set by the vendor must remain in force for at least 1 year

and may only be redetermined by the vendor at the next annual enrollment period. The corporation shall annually assess a surcharge for each premium or price set by a participating vendor. This surcharge may not be more than 2.5 percent of the price and shall be used to generate funding for administrative services provided by the corporation and payments to buyers' representatives.

(7) EXCHANGE PROCESS.--The program shall provide a single, centralized market for purchase of health insurance and health services. Purchases may be made by participating individuals over the Internet or through the services of a participating health insurance agent. Information about each product and service available through the program shall be made available through printed material and an interactive Internet website. A participant needing personal assistance to select products and services shall be referred to a participating agent in his or her area.

(a) Participation in the program may begin at any time during a year when the employer completes enrollment and meets the requirements specified by the corporation pursuant to paragraph (4)(c).

(b) Initial selection of products and services must be made by an individual participant within 60 days after the date on which the individual's employer qualified for participation. An individual who fails to enroll in products and services by the end of this period shall be limited to participation in flexible spending account services until the next annual enrollment period.

(c) Initial enrollment periods for each product selected by an individual participant must last a minimum of 12 months, unless the individual participant specifically agrees to a different enrollment period.

(d) When an individual has selected one or more products and enrolled in those products for at least 12 months or any other period specifically agreed to by the individual participant, changes in selected products and services may only be made during the annual enrollment period established by the corporation.

(e) The limits established in paragraphs (b)-(d) apply to any risk-bearing product that promises future payment or coverage for a variable amount of benefits or services. The limits do not apply to initiation of flexible spending plans when those plans are not associated with specific high-deductible insurance policies or to the use of spending accounts for any products offering individual participants specific amounts and types of health services and treatments at a contracted price.

(8) RISK POOLING.--The program shall utilize methods for pooling the risk of individual participants and preventing selection bias. These methods shall include, but not be limited to, a postenrollment risk adjustment of the premium payments to the vendors. The corporation shall establish a methodology for assessing the risk of enrolled individual participants based on data reported by the vendors about their enrollees. Monthly distributions of payments to the vendors shall be adjusted based on the assessed relative risk profile of the enrollees in each

risk-bearing product for the most recent period for which data is available.

(9) EXEMPTIONS.--

(a) Policies sold as part of the program are not subject to the licensing requirements of the Florida Insurance Code, chapter 641, or the mandated offerings or coverages established in part VI of chapter 627 and chapter 641.

(b) The corporation is authorized to act as an administrator as defined in s. 626.88. However, the corporation is not subject to the licensing requirements of part VII of chapter 626.

(10) LIQUIDATION OR DISSOLUTION.--The Department of Financial Services shall supervise any liquidation or dissolution of the corporation and shall have, with respect to such liquidation or dissolution, all power granted to it pursuant to the Florida Insurance Code.

(11) CORPORATION.--There is created the Florida Health Choices, Inc., which shall be registered, incorporated, organized, and operated in compliance with chapter 617. The purpose of the corporation is to administer the program created in this section and to conduct such other business as may further the administration of the program.

(a) The corporation shall be governed by a board of directors consisting of 15 individuals appointed in the following manner:

1. Five members appointed by and serving at the pleasure of the Governor, consisting of:

a. The Secretary of Health Care Administration or a designee with expertise in health care services.

b. The Secretary of Management Services or a designee with expertise in state employee benefits.

c. The Commissioner of the Office of Insurance Regulation or a designee with expertise in insurance regulation.

d. Two representatives of eligible public employers.

2. Five members appointed by and serving at the pleasure of the President of the Senate, consisting of representatives of employers, insurers, health care providers, health insurance agents, and individual participants.

3. Five members appointed by and serving at the pleasure of the Speaker of the House of Representatives, consisting of representatives of employers, insurers, health care providers, health insurance agents, and individual participants.

(b) Members shall be appointed for terms of up to 3 years. Any member is eligible for reappointment. A vacancy on the board shall be filled for the unexpired portion of the term in the same manner as the original appointment.

(c) The board shall select a chief executive officer for the corporation who shall be responsible for the selection of such other staff as may be authorized by the corporation's operating budget as adopted by the board.

(d) Board members are entitled to receive, from funds of the corporation, reimbursement for per diem and travel expenses as provided by s. 112.061. No other compensation is authorized.

(e) There shall be no liability on the part of, and no cause of action shall arise against, any member of the board or

its employees or agents for any action taken by them in the performance of their powers and duties under this section.

(f) The board shall develop and adopt bylaws and other corporate procedures as necessary for the operation of the corporation and carrying out the purposes of this section. The bylaws shall:

1. Specify procedures for selection of officers and qualifications for reappointment, provided that no board member shall serve more than 9 consecutive years.

2. Require an annual membership meeting that provides an opportunity for input and interaction with individual participants in the program.

3. Specify policies and procedures regarding conflicts of interest, including prohibiting a member from participating in any decision that would inure to the benefit of the member or the organization that employs the member. The policies and procedures shall also require public disclosure of the interest that prevents the member from participating in a decision on a particular matter.

(g) The corporation may exercise all powers granted to it under chapter 617 necessary to carry out the purposes of this section, including, but not limited to, the power to receive and accept grants, loans, or advances of funds from any public or private agency and to receive and accept from any source contributions of money, property, labor, or any other thing of value to be held, used, and applied for the purposes of this section.

(h) The corporation shall:

1. Determine eligibility of employers, vendors, individuals, and agents in accordance with subsection (4).

2. Establish procedures necessary for the operation of the program, including, but not limited to, procedures for application, enrollment, risk assessment, risk adjustment, plan administration, performance monitoring, and consumer education.

3. Arrange for collection of contributions from participating employers and individuals.

4. Arrange for payment of premiums and other appropriate disbursements based on the selections of products and services by the individual participants.

5. Establish criteria for disenrollment of participating individuals based on failure to pay the individual's share of any contribution required to maintain enrollment in selected products.

6. Establish criteria for exclusion of vendors pursuant to paragraph (4)(d).

7. Develop and implement a plan for promoting public awareness of and participation in the program.

8. Secure staff and consultant services necessary to the operation of the program.

9. Establish policies and procedures regarding participation in the program for individuals, vendors, health insurance agents, and employers.

10. Develop a plan, in coordination with the Department of Revenue, to establish tax credits or refunds for employers that participate in the program. The corporation shall submit the plan to the Governor, the President of the Senate, and the

Speaker of the House of Representatives no later than January 1, 2009.

11. Beginning in fiscal year 2009-2010, submit by February 1 an annual report to the Governor, the President of the Senate, and the Speaker of the House of Representatives documenting the corporation's activities in compliance with the duties delineated in this section.

(i) To ensure program integrity and to safeguard the financial transactions made under the auspices of the program, the corporation is authorized to establish qualifying criteria and certification procedures for vendors, require performance bonds or other guarantees of ability to complete contractual obligations, monitor the performance of vendors, and enforce the agreements of the program through financial penalty or disqualification from the program.

Section 5. Subsection (22) of section 409.811, Florida Statutes, is amended to read:

409.811 Definitions relating to Florida Kidcare Act.--As used in ss. 409.810-409.820, the term:

(22) "Premium assistance payment" means the monthly consideration paid by the agency per enrollee in the Florida Kidcare program towards health insurance premiums and may include the direct payment of the premium for a qualifying child to be covered as a dependent under an employer-sponsored group family plan when such payment does not exceed the payment required for an enrollee in the Florida Kidcare program.

Section 6. Section 624.1265, Florida Statutes, is created to read:

624.1265 Nonprofit religious organization exemption; authority; notice.--

(1) Any nonprofit religious organization that qualifies under Title 26, s. 501 of the Internal Revenue Code of 1986, as amended; that limits its participants to members of the same religion; that acts as an organizational clearinghouse for information between participants who have financial, physical, or medical needs and participants with the ability to pay for the benefit of those participants with financial, physical, or medical needs; that provides for the financial or medical needs of a participant through payments directly from one participant to another; and that suggests amounts that participants may voluntarily give with no assumption of risk or promise to pay either among the participants or between the participants and the organization are not subject to any requirements of the Florida Insurance Code.

(2) Nothing in this section prevents the organization described in subsection (1) from establishing qualifications of participation relating to the health of a prospective participant, prevents a participant from limiting the financial or medical needs that may be eligible for payment, or prevents the organization from canceling the membership of a participant when such participant indicates his or her unwillingness to participate by failing to make a payment to another participant for a period in excess of 60 days.

(3) The organization described in subsection (1) shall provide each prospective participant in the organizational clearinghouse written notice that the organization is not an

insurance company, that membership is not offered through an insurance company, and that the organization is not subject to the regulatory requirements or consumer protections of the Florida Insurance Code.

Section 7. Section 627.6562, Florida Statutes, is amended to read:

627.6562 Dependent coverage.--

(1) If an insurer offers coverage that insures dependent children of the policyholder or certificateholder, the policy must insure a dependent child of the policyholder or certificateholder at least until the end of the calendar year in which the child reaches the age of 25, if the child meets all of the following:

(a) The child is dependent upon the policyholder or certificateholder for support.

(b) The child is living in the household of the policyholder or certificateholder, or the child is a full-time or part-time student.

(2) A policy that is subject to the requirements of subsection (1) must also offer the policyholder or certificateholder the option to insure a child of the policyholder or certificateholder at least until the end of the calendar year in which the child reaches the age of 30, if the child:

(a) Is unmarried and does not have a dependent of his or her own;

(b) Is a resident of this state or a full-time or part-time student; and

(c) Is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group, blanket, or franchise health insurance policy or individual health benefits plan, or entitled to benefits under Title XVIII of the Social Security Act.

(3) If, pursuant to subsection (2), a child is provided coverage under the parent's policy after the end of the calendar year in which the child reaches age 25, and coverage for the child is subsequently terminated, the child is not eligible to be covered under the parent's policy unless the child was continuously covered by other creditable coverage without a gap in coverage of more than 63 days. For the purposes of this subsection, the term "creditable coverage" has the same meaning as defined in s. 627.6561(5).

(4)~~(2)~~ ~~Nothing in~~ This section does not affect or preempt ~~affects or preempts~~ an insurer's right to medically underwrite or charge the appropriate premium. (b) Require coverage for services provided to a dependent before October 1, 2008.

(c) Require an employer to pay all or part of the cost of coverage provided for a dependent under this section.

(d) Prohibit an insurer or health maintenance organization from increasing the limiting age for dependent coverage to age 30 in policies or contracts issued or renewed prior to the effective date of this act.

(5) Until April 1, 2009, a dependent child who qualifies for coverage under subsection (1) but whose coverage as a dependent child under a covered person's plan terminated under the terms of the plan before October 1, 2008, may make a written

election to reinstate coverage, without proof of insurability, under that plan as a dependent child pursuant to this section. All other dependent children who qualify for coverage under subsection (1) shall be automatically covered at least until the end of the calendar year in which the child reaches the age of 30, unless the covered person provides the group policyholder with written evidence the dependent child is married, is not a resident of the state, is covered under a separate comprehensive health insurance policy or a health benefit plan, is entitled to benefits under Title XVIII of the Social Security Act, Pub. L. No. 89-97, 42 U.S.C. ss. 1935 et seq., or is eligible for coverage as an employee under an employer-sponsored health plan.

(6) The covered person's plan may require the payment of a premium by the covered person or dependent child, as appropriate, subject to the approval of the Office of Insurance Regulation, for any period of coverage relating to a dependent's written election for coverage pursuant to subsection (3).

(7) Notice regarding the reinstatement of coverage for a dependent child as provided under this section must be provided to a covered person in the certificate of coverage prepared for covered persons by the insurer or by the covered person's employer. The notice shall be given as soon as practicable after July 1, 2008, and such notice may be given through the group policyholder.

(8) This section does not apply to accident only, specified disease, disability income, Medicare supplement, or long-term care insurance policies.

(9) This section applies to all group, blanket, and franchise health insurance policies covering residents of this state, including, but not limited to, policies in which the carrier has reserved the right to change the premium. This section applies to all individual, group, blanket, and franchise health insurance policies and health maintenance contracts issued, renewed, or amended after October 1, 2008.

Section 8. Subsections (41) and (42) are added to section 641.31, Florida Statutes, to read:

641.31 Health maintenance contracts.--

(41) Unless the employer chooses otherwise, for all policies or health maintenance contracts issued or renewed after October 1, 2008, all eligible employees and their dependents shall be enrolled for coverage at the time of issuance or during the next open or special enrollment period, unless the employee provides written notice to the employer declining coverage, which notice shall include evidence of coverage under an existing group insurance policy or group health benefit plan or other reasons for declining coverage. Such notice shall be retained by the employer as part of the employee's employment or insurance file. An employer may require its employees to participate in its group health plan as a condition of employment. This subsection shall apply to all individual, group, blanket, and franchise health insurance policies and health maintenance contracts issued, renewed, or amended after October 1, 2008.

(42) All health maintenance contracts that provide coverage for a member of the family of the subscriber shall comply with s. 627.6562.

Section 9. Subsections (1), (4), and (6) of section 641.402, Florida Statutes, are amended to read:

641.402 Definitions.--As used in this part, the term:

(1) "Basic services" includes any of the following: limited hospital inpatient services, which may include hospital inpatient physician services, up to a maximum of coverage benefit of 5 days and a maximum dollar amount of coverage of $15,000 per calendar year; emergency care; ~~,~~ physician care other than hospital inpatient physician services; ~~,~~ ambulatory diagnostic treatment; ~~,~~ and preventive health care services.

(4) "Prepaid health clinic" means any organization authorized under this part which provides, either directly or through arrangements with other persons, basic services to persons enrolled with such organization, on a prepaid per capita or prepaid aggregate fixed-sum basis, including those basic services described in this part which subscribers might reasonably require to maintain good health. ~~However, no clinic that provides or contracts for, either directly or indirectly, inpatient hospital services, hospital inpatient physician services, or indemnity against the cost of such services shall be a prepaid health clinic.~~

(6) "Provider" means any physician or person ~~other than a hospital~~ that furnishes health care services under this part and is licensed or authorized to practice in this state.

Section 10. This act shall take effect upon becoming a law.

T I T L E A M E N D M E N T

Remove line(s) 473-526 and insert:

An act relating to affordable health coverage; amending s. 112.363, F.S.; specifying that coverage provided through the Cover Florida Health Care Access Program is considered health insurance coverage for the purposes of determining eligibility for the state retiree health insurance subsidy; amending s. 408.909, F.S.; revising eligibility requirements; providing certain exemptions from the 6-month lapse in coverage requirement; extending the expiration date of the health flex plan; creating s. 408.9091, F.S.; creating the Cover Florida Health Care Access Program; providing a short title; providing legislative intent; providing definitions; requiring the agency and the Office of Insurance Regulation of the Financial Services Commission within the Department of Financial Services to jointly administer the program; providing program requirements; requiring the development of guidelines to meet minimum standards for quality of care and access to care; requiring the agency to ensure

that the Cover Florida plans follow standardized grievance procedures; requiring the office and the agency to oversee changes to plan benefits; requiring the Executive Office of the Governor, the agency, and the office to develop a public awareness program; authorizing public and private entities to design programs to encourage or extend incentives for participation in the Cover Florida Health Care Access Program; requiring the agency and the office to announce an invitation to negotiate for Cover Florida plan entities to design a coverage proposal; requiring the invitation to negotiate to include certain guidelines; providing certain conditions under which plans are disapproved or withdrawn; authorizing the agency and the office to announce an invitation to negotiate for companies that offer supplemental insurance or discount medical plans; requiring the agency and the office to approve at least one plan entity; authorizing the agency and the office to approve one regional network plan in each existing Medicaid area; providing that certain licensing requirements are not applicable to a Cover Florida plan; providing that Cover Florida plans are considered insurance under certain conditions; excluding Cover Florida plans from the Florida Life and Health Insurance Guaranty Association and the Health Maintenance Organization Consumer Assistance Plan; providing requirements for eligibility for a Cover Florida plan; requiring each Cover Florida plan to maintain and provide certain records; providing that coverage under a Cover

Florida plan is not an entitlement and does not give rise to a cause of action; requiring the agency and the office to evaluate the program and submit an annual report to the Governor and the Legislature; authorizing the agency and the Financial Services Commission to adopt rules; creating s. 408.910, F.S.; establishing the Florida Health Choices Program; providing legislative intent; providing definitions; providing program purpose and components; providing employer eligibility criteria; providing individual eligibility criteria; providing employer enrollment criteria; providing vendor, product, and service eligibility criteria; providing for individual participation regardless of subsequent job status or Medicaid eligibility; providing individual enrollment criteria; providing vendor enrollment criteria; providing for participation by health insurance agents; providing criteria for products available for purchase; providing criteria for product pricing; providing for an administrative surcharge; providing for an exchange process; providing for enrollment periods and changes in selected products; providing methods for the pooling of risk; providing for exemptions from certain statutory provisions, mandated offerings and coverages, and licensing requirements; creating the Florida Health Choices, Inc.; requiring the department to supervise any liquidation or dissolution of the corporation; providing for corporate governance and board membership and terms; providing for reimbursement for per diem and travel

expenses; providing for powers and duties of the corporation; requiring the corporation to coordinate with the Department of Revenue to develop a plan by January 1, 2009, for creating tax exemptions or refunds for participating in the program; requiring the corporation to submit an annual report to the Governor and Legislature; authorizing the corporation to establish and enforce certain program integrity measures; amending s. 409.811, F.S.; revising the definition of the term "premium assistance payment"; creating s. 624.1265, F.S.; exempting certain nonprofit religious organizations from requirements of the Florida Insurance Code; preserving certain authority of such organizations; requiring such organizations to provide certain notice to prospective participants; providing notice requirements; amending s. 627.6562, F.S.; requiring insurance policies that provide dependent coverage to provide the policyholder with the option of insuring a child until the age of 30 under certain circumstances; amending s. 627.6699, F.S.; requiring participation of employees in health maintenance contracts or policies issued or renewed after a specified date; providing conditions for employers and employees to opt out of such coverage; amending s. 641.31, F.S.; requiring participation of employees in policies or health maintenance contracts issued or renewed after a specified date; providing conditions for employers and employees to opt out of such coverage; requiring all heath maintenance contracts that provide coverage for family members to

comply with certain statutory provisions; amending s. 641.402, F.S.; revising the definition of the term "basic services" to include certain hospital inpatient services; revising the definitions of the terms "prepaid health clinic" and "provider"; providing an effective date.